Intimate Partner Violence Before and During Pregnancy in Missouri 2007 - 2014

Missouri Pregnancy Risk Assessment Monitoring System (PRAMS)

"An estimated 4.9 percent of Missouri women reported physical intimate partner violence (IPV) by a partner or husband before or during pregnancy."

Missouri PRAMS

Missouri PRAMS is an ongoing, population-based survey designed to identify and monitor select maternal experiences, attitudes, and behaviors that occur before, during, and shortly after pregnancy among women delivering a live born infant in Missouri. PRAMS collects information from women through a mailed survey with telephone follow-up for those who do not respond. Responses are then weighted to represent all live Missouri births in a given year.

In Missouri, 10,098 women responded to the survey in 2007-2014, for an average weighted response rate of 69 percent.

This fact sheet describes physical intimate partner violence before or during pregnancy by a husband or partner from 2007-2014.

Intimate Partner Violence

The U.S. Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as physical, sexual, or psychological harm by a current or former partner or spouse.

IPV can vary in severity and frequency. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy. This is a serious, preventable public health problem that affects millions of Americans.

IPV before and during pregnancy can lead to serious maternal and neonatal outcomes such as hypertension, gestational diabetes, placental problems, infections, and mood disorders, including post-traumatic stress disorder.[1,2] Adverse neonatal outcomes include preterm birth, small for gestational age and low birth weight.[1,2]

IPV during pregnancy is also associated with adverse health behaviors, including smoking, alcohol and substance abuse, and delay in prenatal care.[3] A U.S. population-based survey showed that women who had unwanted or mistimed pregnancies reported significantly higher levels of abuse during pregnancy compared to those with intended pregnancies (15% versus 5%).[4] Risk factors for IPV before and during pregnancy are similar to risk factors for IPV among the general population. Many studies have shown that IPV may be associated with race, socioeconomic status (SES) and may contribute to racial disparities in perinatal outcomes. But more research is needed to fully understand these associations.[2]

In Missouri, PRAMS provides the best opportunity to study the risk of physical IPV before and during pregnancy. The PRAMS survey asks two questions that report whether women have experienced IPV before or during pregnancy. Women are counted as reporting IPV if they have answered "yes" to either of the following questions:

1. "During the 12 months before you got pregnant, were you physically hurt in any way by your husband or partner?"
2. "During your most recent pregnancy, were you physically hurt in any way by your husband or partner?"

Physical Intimate Partner Violence Before or During Pregnancy in Missouri

Figure 1 shows that overall, from 2007-2014, an estimated 4.9 percent of Missouri women reported being physically hurt by their husband or partner before or during pregnancy. Of these, 4.0 percent were subjected to physical IPV before pregnancy and 3.0 percent during pregnancy.

Figure 1. Prevalence of physical intimate partner violence by a husband or partner before or during pregnancy

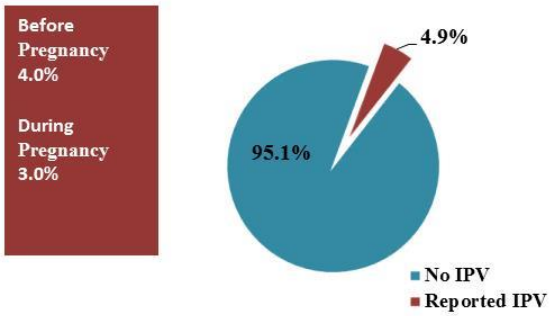
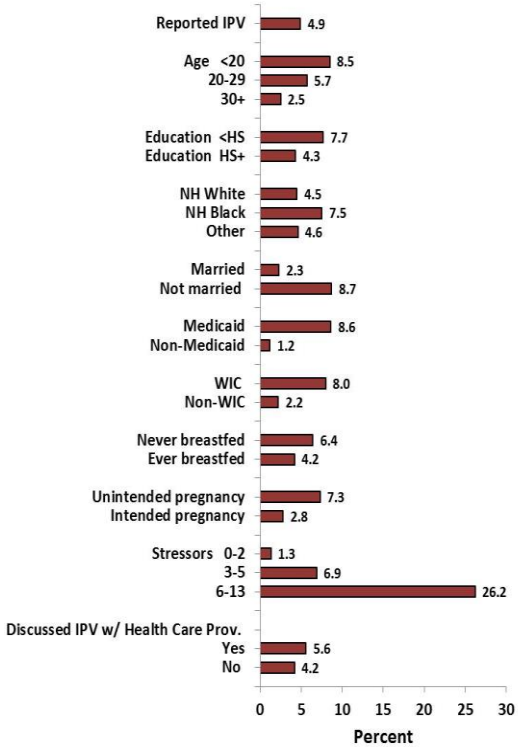


Figure 2 shows that the prevalence of physical IPV before or during pregnancy by a husband or partner is more common among women who were:

- Under 20 years old.
- Non-Hispanic (NH) Black / African-American.
- Unmarried.
- Less than high school (HS) educated.
- Covered by Medicaid.

Figure 2. Prevalence of physical IPV before or during pregnancy, Missouri PRAMS 2007-2014



While Missouri PRAMS does not collect specific information with respect to barriers health care providers are facing in relation to IPV screening, other studies have shown that lack of knowledge about IPV and lack of knowledge of effective follow-up to disclosure are among leading barriers providers cite for not performing IPV screening.[1,6,8,9,10,11,12]

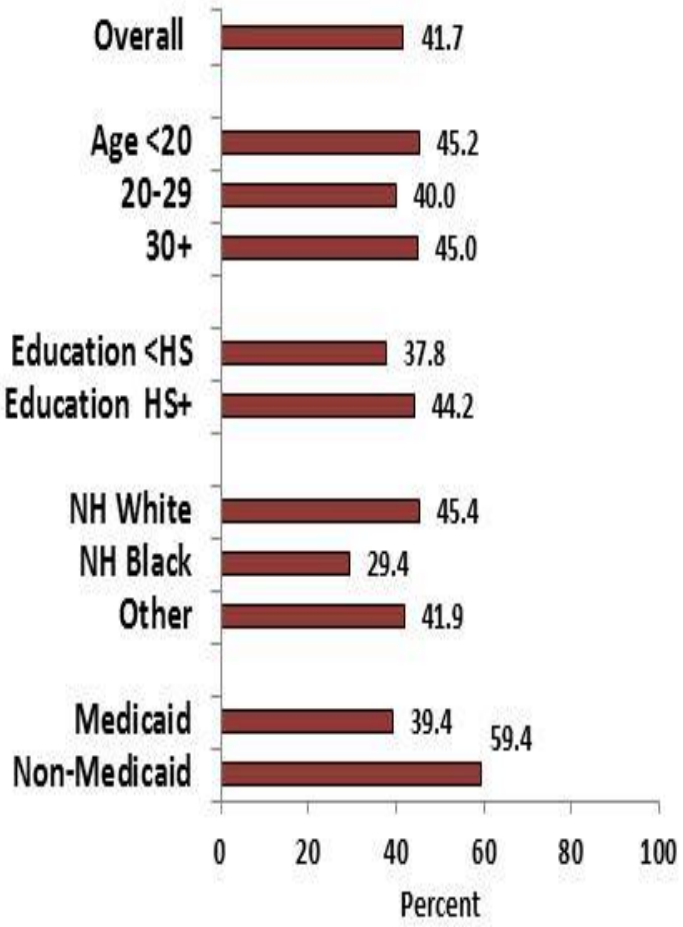
Women who report physical IPV come from all backgrounds: 10.8 percent of women in the lowest income bracket (<$15,000 annual income) reported IPV, as did 7.3 percent of PRAMS respondents with an unintended pregnancy, and 26.2 percent of new moms who also reported experiencing at least six of a defined list of maternal stressors.

IPV Discussion with Health Care Provider among Missouri Pregnant Women

IPV is a significant but preventable public health problem. The U.S. Department of Health and Human Services and Institute of Medicine recommends that IPV screening and counseling should be part of women's health visits.[5]

Among the new mothers in Missouri who reported physical abuse before or during pregnancy, 58.3 percent (95% CI: 52.9-63.7) reported that a health care provider discussed IPV with them during prenatal care and 41.7 percent (95% CI: 36.3-47.1) did not discuss IPV during prenatal care (see Figure 3).

Figure 3. Percentage of new mothers reporting IPV who did not discuss IPV with health care provider



Discussion

Intimate Partner Violence during pregnancy affects a significant number of women in Missouri and varies among sub-populations. Due to social stigma, IPV remains underreported.

Screening for IPV is essential, yet due to time constraints and unclear recommendations for assessment, many prenatal care providers do not routinely inquire about IPV.[1,8,9] Barriers to screening persist, and studies show that provider-related barriers are reported more often than patient-related barriers.[11,12]

Limitations

PRAMS data are subject to several limitations. First, PRAMS is a self-reported survey administered two to four months after the birth of the child, and results may be subject to recall bias. Second, it is possible that weighting might not completely adjust for bias resulting from non-response. Third, MO PRAMS surveys are sent to a sample of women who delivered live births in Missouri, and data are not generalizable to pregnant women with other outcomes or in states outside Missouri.

Screening practices should include provider/staff education and training, focusing not only on the IPV issue, but how to relate this information to clients and discuss IPV in a safe, empowering way (HHS, 2002).

Missouri Mothers Say…

"Violence was a big part in my pregnancy. Violence and pregnancy does not go well together. I needed help and did not know where to go for help."

Barriers to IPV Screening by Health Care Providers (HCP)

(1,6,8,9,10,11,12)

Lack of Resources

- Lack of screening procedures and awareness.
- Lack of staff for victim education, legal advocacy and referral.
- Lack of office protocol.

Attitudes and Perceptions

- HCPs believe screening is not their responsibility.
- Belief that they don't make much difference.

Personal Barriers

- Feeling discomfort in asking the patients.
- Concern of misdiagnosis.

Lack of Knowledge and Training

Language Barrier

Lack of Time

Recommendations

The American College of Obstetricians and Gynecologists (ACOG) recommends that all health care providers screen for IPV, offer ongoing support and review available prevention and referral options. According to ACOG, screening should take place at:[6]

- Routine annual examinations.
- First prenatal visit.
- Least once per trimester.
- Postpartum checkup.

The Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey recommends that all sectors of society, including individuals, families and communities, need to work together to end IPV.

Strategies include:

- Promoting healthy, respectful relationships in families by fostering healthy parent-child relationships and developing positive family dynamics and emotionally supportive environment.[7]
- Providing coordinated services for survivors to ensure healing and work to prevent recurrence of victimization.[8,9]
- Identifying barriers affecting screening practices before implementing policies and procedures.[8]

Resources

National Domestic Violence Hotline: 800-799-7233 or 800-787-3224 (TTY)
National Teen Dating Abuse Helpline: 866-331-9474 or 866-331-8453 (TTY)
National Sexual Assault Hotline: 800-656-4673

Missouri Resources

Missouri Coalition against Domestic and Sexual Violence, www.mocadsv.org/
Missouri Department of Health and Senior Services, Office on Women's Health, health.mo.gov/living/families/womenshealth/index.php
Missouri Safe at Home Address Confidentiality Program, https://www.sos.mo.gov/business/safeathome/about

National Resources

American College of Obstetricians and Gynecologists, www.acog.org/
Centers for Disease Control and Prevention (CDC), Intimate Partner Violence, www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html
Children's Safety Network, https://www.childrenssafetynetwork.org/injury-topics/familyintimate-partner-violence
Futures without Violence National Health Resource Center on Domestic Violence, www.futureswithoutviolence.org/
National Coalition against Domestic Violence, www.ncadv.org/
National Online Resource Center on Violence against Women, http://vawnet.org/
National Resource Center on Domestic Violence, www.nrcdv.org

Data Resources

Missouri Pregnancy Risk Assessment Monitoring System, http://health.mo.gov/data/prams/index.php
National Violent Death Reporting System (NVDRS), www.cdc.gov/violenceprevention/nvdrs/index.html
The National Intimate Partner and Sexual Violence Survey (NISVS), www.cdc.gov/violenceprevention/NISVS/index.html
Youth Risk Behavior Surveillance System (YRBSS), www.cdc.gov/healthyyouth/data/yrbs/index.htm

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